



## The role of government in health care: a societal issue

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### Abstract

The history of the role of government in health care is briefly reviewed and more fully discussed in the United States since the establishment of Medicare 40 years ago. Data and other evidence of the unintended consequences of this historic event are presented, identifying thorny and onerous issues that government has created, showing failed attempts at band-aid solutions, and suggesting that our present health care system is in disarray and cannot be rectified by the “incrementalism” approach. The establishment of a high-level commission jointly endorsed by the President of the United States and Congress is recommended to consider and analyze scrupulously all the components of our health care complex and provide a “roadmap” toward achieving a universal health care system that is culturally acceptable, affordable, and of optimal quality while avoiding its administration and total control by an ultimately rigid and unwieldy governmental or insurance-industry bureaucracy. © 2006 Excerpta Medica Inc. All rights reserved.

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For centuries, prominent figures have recognized the primacy of the health of the people. In 300 BC, the Greek anatomist and surgeon Herophilus wrote: “To lose one’s health renders science null, art inglorious, strength unavailing, wealth useless, and eloquence powerless” [1]. In 1787, Thomas Jefferson cautioned: “With your talents and industry, with science, and that steadfast honesty which eternally pursues right, regardless of consequences, you may promise yourself everything but health, without which there is no happiness. An attention to health then should take place of every other object” [2]. And in a speech in 1877, Benjamin Disraeli observed, “The health of the people is really the foundation upon which all their happiness and all their powers as a state depend” [3].

For many years, and particularly during the past half century, concern has intensified in both the United States and Western Europe about the cost, accessibility, and quality of health care for *all* the people. With impressive advances in molecular biology and the understanding of disease processes, in medical technology, and in

pharmaceutical therapeutics, much more effective treatment has become available for a widening array of diseases. As a consequence, however, costs have steadily risen, while a substantial proportion of society, some in poor health, has little or no ready access to these services. As a result, medical policy issues occupy increasing political attention, with sometimes bitter disputation among various societal segments, including federal and state officials, congressmen, medical practitioners, social scientists, economists, health insurers, business leaders, and others. The essence of this controversy lies in the role of state intervention, particularly the extent to which it controls the provision, funding, and regulation of medical services. Opponents of state intervention and proponents of “privatization” contend that the deeper government becomes involved in health care, the more bureaucratic, complex, inefficient, and inferior the services [4–7]. Advocates of state intervention, on the other hand, argue that government participation is the best way to improve both cost-effectiveness and accessibility of health services [8–11].

Historically, federal or state officials in various countries have intervened intermittently in medical or health activities, including particularly the licensing of medical practi-

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tioners, public health policies, and even regulation and control of medical practice. More than 4,000 years ago, King Hammurabi of Babylonia established a codification of medicine that included fees paid to physicians for satisfactory services, as well as penalties, sometimes draconian, for harmful services [12]. According to Magner [13], the *Artha Sastra* written for Chandragupta Maurya, who reigned in India in the third century BC, “contains many laws . . . regulating medical practitioners, midwives, nurses, drugs and poisons, prostitution, sanitation and public health.” As early as the 12th century, Roger II of Sicily established certification of physicians, requiring them to pass an examination [14]. In the next century, his grandson, Fredrich II, expanded the process to require all candidates for medical licensure to be publicly examined after a 9-year curriculum [14]. In addition, he also established a sanctioned schedule of fees. In the Middle Ages, isolation and quarantine of certain patients were required as public health measures to control epidemics.

The increasing intrusion and ever-expanding role of federal or state government in health care began in Europe during the Industrial Revolution of the 18th and 19th centuries. To some extent, this derived from the sickness-fund system that had been developed much earlier by guilds, craftsmen, and miners. In the 19th century, major economic and social changes followed the dramatic shift from a feudal to an industrial society and from agrarian laborers to factory workers. As a result, Germany established the first social insurance for health care. The world’s first national health insurance program, in fact, became German law in 1883, when it was launched by Chancellor Otto Edward von Bismarck [15,16]. Originally, he envisioned a government-operated, centrally administered health service “to coopt the socialists,” as Richard Knox [17] wrote, “and blunt socialism’s appeal for restive laborers,” who were encouraged by the disciples of Karl Marx. Because of strong opposition to this centralized plan by business and agricultural interests in the Reichstag, as well as by conservatives and provisional governments, Bismarck compromised with a national health insurance program operated by “sickness funds” (*Krankenkassen*). Knox noted that this “sickness funds” model marries “federal government superintendency with private financing and administration by autonomous institutions” [17]. Although universal coverage was not required by the original law, the “sickness funds” model, along with statutory insurance, has expanded to provide coverage for increasing segments of society and, indeed, virtually the entire German population. Other countries in Europe soon followed in establishing national health insurance programs with some major variations in the systems [18].

### Health Care and Government in the United States

In the United States, the role of federal or state intervention in health care lagged far behind Europe for a number of

reasons. Historically, medical education and clinical training were not standardized in the United States, consisting largely of preceptorships and “reading for medicine,” with the development, toward the end of the nineteenth and early twentieth century, of proprietary medical schools of generally poor quality. State licensing examination boards began only in the 1870s but were established in all states by 1898. In 1900, only 10% of American practicing physicians were graduates of an established medical school, and it was another 20 years before all new medical practitioners were graduates of such schools, following the efforts of the American Medical Association and the Flexner Report in 1910 [19].

Another influential factor in health care is the profit motive, which is culturally related to the enterprising commercial spirit of America. Still another, and perhaps the most important, factor according to Hollingsworth [20] is “a lack of a sense of community” in the United States versus the European cultural concept of “social solidarity” and the social-Darwinist attitudes [21]. Volunteerism, however, has developed into a cultural characteristic of American society, as evidenced by the large number of institutions of higher learning, hospitals, philanthropic foundations, and various non-profit organizations that have been founded and supported by religious and other private groups and by wealthy donors.

Consideration of a national health insurance system in the United States was first proposed in 1915 by the American Association of Labor Legislation, a relatively small organization of fewer than 3,500 members, primarily social scientists, academicians, and lawyers [18,22,23]. The organization’s publication of a draft of a bill proposing compulsory health legislation in November 1915 [24] immediately led to intense discussions and debates for and against compulsory health insurance. Numbers [18] cited strong support for the concept by the “institutional” segment of the medical profession, that is, public health officers, hospital officials, and the teaching faculty of the larger medical schools. Vehement opposition to this program, especially by the medical practitioners and the insurance industry’s Economic Society, developed after the organization proposed a specific bill [24]. Interestingly, Samuel Gompers, one of the most influential labor leaders in the country at that time, vigorously opposed the bill, arguing that “the solution to illness was not compulsory insurance but higher wages” [25].

In the early part of these discussions, after the American Medical Association (AMA) appointed a Committee on Social Insurance, a number of opinions were expressed in issues of the *Journal of the American Medical Association* lending support to the concept of health insurance, as exemplified by the following statement: “It is hoped that physicians will take advantage of this opportunity and that it will be possible to avoid that lack of cooperation between the physicians and legislators which, for a time, marred some of the foreign legislation” [26]. The commercial insurance com-

panies strongly opposed the bill, and resistance intensified among state medical societies [18]. With the declaration of war against Germany in 1917, “anti-German” sentiment deepened against compulsory health insurance and the German sickness insurance system (*Krankenkassen*). After the end of World War I, efforts to revive the concept met with strong disapproval, as reflected in the establishment of a strong policy against all systems of compulsory health insurance by the House of Delegates of the AMA at its meeting in New Orleans on April 27, 1920, and in the following resolution adopted at that meeting by the AMA Reference Committee on Hygiene and Public Health: “Resolved, That the American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness, or any other plan of compulsory insurance which provides for medical service to be rendered contributors or their dependents, provided, controlled, or regulated by any state or the Federal Government” [27]. As will be observed later, the AMA devoted major, highly publicized efforts for many years to battling federal or state intervention in health care.

Legislative considerations for governmental national health insurance were renewed after President Roosevelt signed the Social Security Act in 1935. In 1939, Senator Wagner introduced a bill outlining a broad federal health program, but it failed to win adequate support for enactment. During the Truman administration in 1951 to 1952, this type of governmental medical support was reintroduced as the Ewing proposal, and bills were submitted in Congress, but no action was taken [23].

Despite that negative background, on July 30, 1965, President Lyndon B. Johnson signed the bill creating Medicare, which introduced state intervention in health activities for the first time in the United States and opened the way for an expanding role of government in medical practice [21,28]. Interestingly, Arthur Fleming, Secretary of Health, Education, and Welfare during the Eisenhower administration, attached the label, “Medicare,” as a state-sponsored-means health program he proposed [29]. For more than a decade before Medicare was signed into law, a bitter and often vituperative debate prevailed, intensifying especially during the Kennedy administration [30–32]. A personal experience illustrates the height of passion in the medical community. President Kennedy had campaigned on the issue in 1960 and strongly supported legislation for this purpose. In the meantime, the AMA’s opposition had become increasingly strident. Members were assessed dues to create a \$3.5 million war chest to conduct a public campaign against such legislation. At that time, I received a call from an aide to President Kennedy, advising me that the President had scheduled a press conference in the Rose Garden with prominent physicians who supported the Medicare legislation to combat the AMA’s contention that all physicians opposed it. The aide, who knew of my support for the legislation from previous discussions, stated that President

Kennedy would like me to attend the press conference and asked that I invite as many surgical colleagues as I could in other medical schools to join me in attending. I accepted his invitation, but every 1 of 20 professors of surgery I called declined for a variety of reasons. When I arrived at the White House, I found only about 15 other physicians there, most of whom were not active or prominent practitioners.

In light of the AMA’s strong opposition to this legislation, the earlier AMA position is especially noteworthy in the following quotation from a 1917 report of its Committee on Social Insurance: “The time to work them out, however, is when the laws are moulding, as now, and the time is present when the profession should study earnestly to solve the questions of medical care that will arise under various forms of social insurance. Blind opposition, indignant repudiation, bitter denunciation of these laws is worse than useless; it leads nowhere and it leaves the profession in a position of helplessness if the rising tide of social development sweeps over them” [33].

### Advocacy of Medicare

During my advocacy of Medicare, I did not consider it to be a step toward national health insurance, as the AMA labeled it [30], but a worthy humanitarian way of ministering to impoverished or low-income patients. Accordingly, I was astonished decades later to read the reflections of Robert M. Ball, President Kennedy’s Commissioner of Social Security, on what Medicare’s architects had in mind: “. . . the first broad point to keep in mind is that all of us who developed Medicare and fought for it—had been advocates of universal national health insurance. We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically. Although the public record contains some explicit denials, we expected Medicare to be the first step toward universal national health insurance, perhaps with ‘Kiddicare’ as another step” [34].

Ten years ago, on the 30th anniversary of the Medicare legislation, there were widespread discussions, debates, critical analyses, and projected proposals concerning the program. This controversy is symbolized by the title of the commentary by Dr Jordan J. Cohen [35], President of the Association of American Medical Colleges, “Happy (?) Birthday, Medicare.” Almost everyone agreed that the program had been successful in achieving most of the goals and expectations of its founders. It provided financial relief and access to health care for all elderly people, as well as for all 37 million patients with disabilities and end-stage renal disease [36]. Indeed, it underwrote health insurance coverage for about 25% of all Americans. Some maintain that it has contributed to increased longevity among the elderly [37].

Particularly significant is the role Medicare has played in the health care system, accounting in 2002 for about 30% of all hospital services, more than 20% of expenditures for

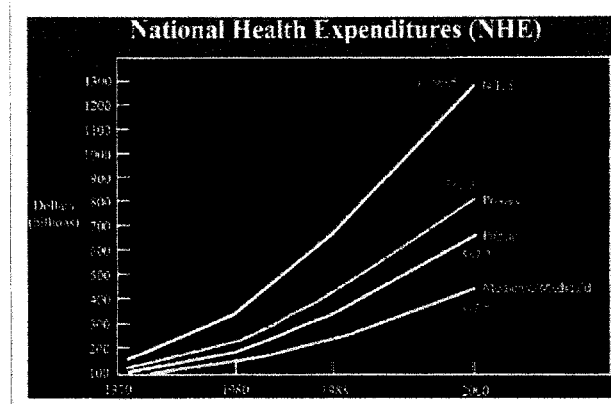


Fig. 1. Graph showing increase in health expenditures from 1970 to 2000 based on data from Wallace, Green, and Jaros [45].

physician services (with the addition of Medicaid, the figures become 47% and 27%, respectively), and a substantial proportion of the revenue for home health care agencies, hospices, renal dialysis facilities, laboratories, and ambulance services [38]. No less significant have been the supplemental payments Medicare has made to support medical education, based on the admirable acknowledgement by Congress in 1965 that "... educational activities enhance the quality of care in an institution, and it is intended ... that a part of the net cost of such activities including stipends of trainees, as well as compensation of teachers and other costs should be borne to an appropriate extent by the hospital insurance programs ... " [39].

### No Free Lunches

In the meantime, however, national health outlays have risen exponentially, reflected in the rapid escalation of expenditures after Medicare's implementation and showing the magnitude of faulty fiscal cost projections made by legislators. From its very beginning, the cost of Medicare has been an issue; within 6 months after its onset, President Johnson ordered an inquiry into the rising costs [29]. Whereas the budget for the first year was \$1 billion, Medicare actually paid out \$4.6 billion [5] (some reported \$3.2 billion [24] and \$3.4 billion [23]). Ten years later, the cost had climbed to \$21.8 billion [40]. Medicare/Medicaid spending has risen 40-fold from \$10.5 billion in 1970 to \$414.6 billion in 2002 [38]. Moreover, the projection by federal actuaries of a \$10 billion outlay for Medicare in 1990 amounted to only about one tenth of actual expenditures [41,42]. From 1970 to 2000, for example, Medicare expenditures increased 30-fold from \$7.7 billion to \$224.4 billion as the eligible population for Medicare expanded from \$26 million to \$38.6 million [43]. The cost of Medicaid to the states and the federal government is projected to reach \$380 billion this year [44]. The rapid ascent in total

health expenditures is evident in the rise from \$73.1 billion in 1970 to \$1,299.5 trillion in 2000 and in public expenditures (Medicare, Medicaid) from \$10.5 billion in 1970 to \$342.8 billion in 2000 [45] (Fig. 1). Of particular significance is the increasing impact of federal and state payments for personal health care; in 1960 they represented only 22% of total health expenditures, but in 2002 they had expanded to 45% [46].

The explosive growth in Medicare and national health care costs is attributable to a number of factors, including an increase in population (with a continuing expansion of the elderly segment projected to be more than 45 million in the next 10 years), burgeoning administrative costs, and perhaps of major importance, the rapid explosion of advances in medical technology [45], with costly new diagnostic equipment, medications, and surgical procedures, such as coronary artery bypass and hip replacement. Spending on prescription drugs has increased from 6% in 1980 to 12% in 2003, having almost tripled in the 1990s alone to more than \$130 billion by 2001 [42,46]. Projections of the impact of the growing aging population on Medicare and Medicaid, as well as on social security entitlements, will increase dramatically, with expenditures for both programs possibly reaching \$4 trillion by 2025 [42] (Fig. 2). This inspired *The New York Times*, on March 30, 2005, to headline its concern with, "Medicare Outlook Called Direr than Social Security's." These costs will be aggravated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, comprising 680 pages, originally estimated to cost about \$400 billion over the next 10 years [47,48], but even within a month after the Act was signed into law, the President's Office of Management and Budget announced that it budgeted the cost to be \$534 billion [49]. Some economists projected it to be as high as \$724 billion [50] and soaring to more than \$3 trillion over time [51]. Moreover, as emphasized by Cosman [7], "In fewer than a dozen years, the 41,000,000 people currently on Medicare and the 47,000,000 on Medicaid will suffer a tidal wave of new fervent competitors for 'free' medical care. The first wave of 77,000,000 Baby Boomers hits

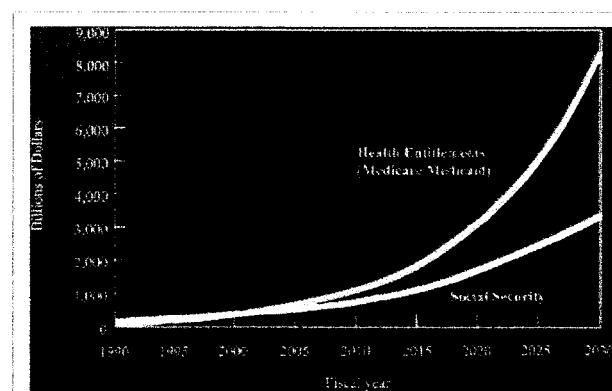


Fig. 2. Projected costs of entitlement for Medicare/Medicaid and Social Security 1990 to 2030. Constructed from data in Social Security Trust Fund Trustee's Report, 1990, and Health Care Financing Administration, Office of the Actuary, December 1990.

shore in 2010. Who will be left working to pay for Medicare?" In 15 years, a projected one fourth of all federal income taxes will be used for Medicare [50]. In 25 years, an estimated 25% of the population in the United States will be beyond the age of 65 compared with about 17% today [51]. According to both the Congressional Budget Office and General Accounting Office, federal spending policies are unsustainable and could require a considerable increase in taxation or debt levels that could adversely affect the economy [52]. A Medicare trustee has projected that Medicare's inpatient hospital coverage, Part A, will become insolvent in 2020 [53].

The rapid escalation in health care spending to 9.3% greatly exceeds economic growth of only 3.6% [38], soaring well above inflation, increasing from \$23.4 billion in 1960 to about \$1.7 trillion currently [46]. Economists are projecting a rise to 16.2% of the gross domestic product (GDP) in 2008, an increase in national health expenditures to more than \$2.2 trillion in 2008 [42], and to \$3.6 trillion in 2014 [54], with health care projected to consume 25% of the GDP by 2030 [55]. (In 1960, health care expenditure was only about 4% of GDP and by 2003 it had risen to 13% of GDP [44].) As a result of these runaway figures, administration officials, congressmen, public and private third-party payers, and, of course, social scientists and economists all began discussing ways of decelerating health care expenditures. Physicians, the toilers in the field, were largely ignored in these heated and sometimes frenzied, if not always rational or informed, discussions.

Administrative costs have also continued spiraling as the health care environment has become increasingly complex, with well over 1,200 insurers in addition to Medicare and Medicaid. The number of administrators has expanded disproportionately to the number of physicians; from 1970 to 1995, the number of US physicians increased by about 25%, whereas the number of administrators rose by more than 2,000% [42]. It is no wonder that administrative costs are estimated to represent 24% to 30% of annual United States health expenditures [11,56].

An additional and not inconsequential factor in this connection is rising medical litigiousness, causing excessive malpractice premiums, sometimes forcing physicians in high-risk specialties to move or leave their practices [57]. Moreover, the adaptations in practice to avoid lawsuits, such as unnecessary tests and procedures, increase patient care costs and discourages efforts to improve quality. The public is beginning to realize the current trends cannot continue [58]. Unfortunately, at this time, tort reform for this purpose in the proposed "HEALTH" Act of 2005 in Congress appears to be stalled [59].

### Failed Solutions

With the ostensible purpose of "cost containment," Medicare officials instituted Diagnosis-Related Groups (DRG), Prospective Payment Systems (PPS), and Resource-Based Rel-

ative Value (RBRV) Scales [60,61], along with a series of regulations and increasingly oppressive administrative burdens. In Cosman's words, American physicians "abide by voluminous federal and state laws and regulations often mutually contradictory, vague, and arbitrary" [7]. The hydra-headed Medicare rules and regulations occupy more than 132,000 pages [51,62], inevitably magnifying the federal regulatory role.

For a lecture entitled "Clinical Freedom," Sir Raymond Hoffenberg [63], then President of the Royal College of Physicians, analyzed the "winds of change" in medicine in Great Britain and the United States during 4 decades of state medical service: "... on balance, despite our recruitment to a State-run service, we have retained a substantial degree of clinical autonomy, perhaps—one might venture—some-what more than our colleagues in America who are less overtly subject to government control." Furthermore, he quoted George Silver [64] as follows: "... the British doctor, discontented as he or she may be with inadequacies of the financial rewards of practice in the U.K., or dissatisfied with the shabby and inadequate facilities in many places in which medical work is performed, is still largely free and untrammelled in the practice of medicine... [whereas] American physicians... are pinioned by regulations and controls far beyond... colleagues in most other countries." Somewhat similar sentiments were expressed by the late Eli Ginzberg [65], "... the earlier untrammelled freedom of the profession to determine how, where, and for how long patients would be treated is being circumscribed by new rules, regulations and protocols."

### Managed Care

The emergence of "managed care" plans also addressed "cost containment." The concept of prepaid group practice as a mechanism for deceleration of health care expenditures actually arose during the Nixon administration, which, with a Democratic-controlled Congress, enacted the Health Maintenance (HMO) Act of 1973 [66]. Unfortunately, most for-profit HMOs have concentrated on substantial financial returns for *investors* rather than on quality and quantity of service, and so have used various tactics to curtail the time the physician devotes to the patient (12 minutes by some HMOs) [67], as well as the number of laboratory examinations and other procedures ordered and the referrals to specialists. Since each additional examination or treatment reduces profitability, the "cost-containment" policy encourages doing as little as possible for the patient; failure to observe such "cost containment" is termed "medical revenue loss" [68]. Obviously, these constraints can adversely affect the quality of health care. My own experiences with this effect are exemplified by a Medicare patient enrolled in an HMO [67]. At the request of the patient's sons, I saw in consultation a 76-year-old man with complaints of transient episodes of slurring of speech and weakness in the right

Table 1  
Insurance companies' top earnings per share (EPS)—2003

Firm	Income	Profit	EPS	Dividends
Wellpoint	\$20.4 B	\$935 M	\$6.16	0
Aetna	\$18.0 B	\$934 M	\$5.91	\$0.04
Anthem	\$16.8 B	\$779 M	\$5.45	0
Cigna	\$18.8 B	\$620 M	\$4.75	\$1.32
Oxford Health Plans	\$5.45 B	\$352 M	\$4.15	\$0.10

Financial data (2003) for the 5 health insurance companies with the highest EPS.

Data from *The Wall Street Journal* Online (www.online.wsj.com) [69].

arm. Examination disclosed loud murmurs over the carotid arteries, indicating a narrowing of the vessels, which could account for his symptoms. In addition, and more life-threatening, a large aneurysm of the abdominal aorta, measuring about 10 cm in diameter, was found. Yet, neither condition had been diagnosed by the HMO physician, who, according to the patient, had not even performed a physical examination. Because the tests I recommended were not approved, the patient asked to be released from the HMO to regain Medicare status and obtain proper treatment, but, according to his sons, he was given the "runaround" for several months and then died in his sleep. An autopsy demanded by his sons indicated that death was caused by rupture of the aneurysm.

### Diversion of Funds From Health Care to Corporate Executives and Administration

The draconian measures imposed by HMOs and other health insurers purportedly to "hold down costs" have failed woefully in that regard while proving inordinately profitable for the HMOs. In 1994, 9 of the largest publicly traded HMOs accumulated a profit of \$9.5 billion in cash and marketable securities, amassed largely by financially squeezing hospitals and physicians and limiting high-technology care [67]. Total compensation for the top executives of 28 for-profit

Table 2  
Insurance companies' CEO pay—2003

Firm	Compensation	Options
Wellpoint	\$7,284,795	\$95,586,716
Aetna	\$6,677,005	\$18,639,480
Anthem	\$6,857,839	0*
Cigna	\$2,191,000	\$3,785,890
Oxford Health Plans	\$1,378,792	\$11,118,459

Compensation (salary and bonus) as well as options held by the chief executive officers of the 5 health insurance companies in 2003 with the highest EPS.

\* Anthem announced on April 7, 2004, that its CEO will receive a \$42 million merit award because Anthem's profit grew an average of 41% per year during a 3-year period.

Data from *The Wall Street Journal* Online (www.online.wsj.com) [69].

Table 3  
Hospital corporations' top EPS—2003

Firm	Income	Profit	EPS	Dividends
Universal Health Services	\$3.64 B	\$199 M	\$3.20	0
HCA Inc.	\$21.8 B	\$1.3 B	\$2.61	\$0.08
LifePoint Hospitals Inc.	\$907 M	\$68.5 M	\$1.76	0
Symbion Inc.	\$145 M	\$12.3 M	\$1.01	0
Community Health Systems Inc.	\$2.83 B	\$131 M	\$2.29	0

Financial data (2003) for the 5 hospital corporations with the highest EPS. Data from *The Wall Street Journal* Online (www.online.wsj.com) [69].

HMOs increased 49% in 1993, and the average annual compensation for the executives was \$1.05 million, with some reaching as high as \$10 million [67].

Recent data compiled by the *Wall Street Journal* for 2003 discloses a capitalist-dominated, profit-driven United States health care industry [69]. Among the top 5 health insurance companies, the income ranged from more than \$5 billion to more than \$20 billion, with profits ranging from \$352 to \$935 million (Table 1). Equally astonishing are the annual incomes of the insurance company CEOs, with salaries ranging from more than \$1 to more than \$7 million and options as high as \$95 million (Table 2). Incomes for the top for-profit hospital corporations range from \$145 million to more than \$21 billion, and profits range from \$12 million to \$1.3 billion (Table 3). The munificent incomes of the CEOs of these for-profit hospital corporations range from \$597,751.00 to more than \$20 million in salaries, with options as high as \$27 million or more (Table 4). DeAngelis [70] aptly assessed these organizations thus: "Actually, most are managed *cash* organizations; the care is manipulated to ensure profitable cash flow that ends up in the pockets of the chief executive officers and stockholders" [70]. To those of us who entered medicine to follow a noble humanitarian tradition of helping those suffering from disease and disability, placing profit above the welfare of the patient is both immoral and iniquitous.

The figures for pharmaceutical corporations are comparable. Income for the top 5 companies ranged from \$294 million to more than \$32 billion, with profits ranging from \$59 million to more than \$6 billion (Table 5). Compensation of the pharmaceutical CEOs was also extravagant,

Table 4  
Hospital corporations CEO pay—2003

Firm	Compensation	Options
Universal Health Services	\$20,816,343	\$27,141,176
HCA Inc.	\$3,451,856	\$19,201,323
LifePoint Hospitals Inc.	\$1,134,055	\$8,176,082
Symbion Inc.	\$597,751	\$394,389
Community Health Systems Inc.	\$1,262,649	\$7,590,000

Compensation (salary and bonus) as well as options held by the chief executive officers of the 5 hospital corporations in 2003 with the highest EPS.

Data from *The Wall Street Journal* Online (www.online.wsj.com) [69].

Table 5  
Pharmaceutical companies' top EPS—2003

Firm	Income	Profit	EPS	Dividends
Merck	\$22.5 B	\$6.59 B	\$3.03	\$1.45
Kos	\$294 M	\$59.4 M	\$1.53	0
Eli Lilly & Co	\$12.6 B	\$2.6 M	\$2.37	\$1.34
Novartis	\$32.4 B	\$5.74 M	\$1.87	\$0.74
Abbott	\$19.7 B	\$2.75 M	\$1.75	\$0.98

Financial data (2003) for the 5 pharmaceutical companies with the highest EPS.

Data from *The Wall Street Journal Online* (www.online.wsj.com) [69].

ranging from more than \$2 million to more than \$63 million (Table 6).

The HMOs achieved high profitability by taking advantage of the excess capacity in hospitals and medical services and by gouging physicians and hospitals to make contractual arrangements at prices that barely meet, and sometimes fall below, actual costs. This has been aptly described as exhibiting “many aspects of monopsony power in their dealings with hospitals and physicians . . .” [71]. Moreover, the HMOs refuse to pay for any educational or training costs, resulting in closure of some hospitals and serious financial crises in some medical schools [72]. Such parsimony is shortsighted, for these institutions are a crucial source of future well-trained physicians and new medical knowledge that leads to improved diagnosis, treatment, and cure. In the rising backlash against HMO policies of minimal services at higher costs, bills have been introduced in Congress for “patient rights” and in some state legislatures for the right of patients to sue HMOs. With abrogation of these HMO promises, patients are rebelling.

### Adverse Effects on Academic Medical Centers

Perhaps a more significant “cost-containing” development by the federal government is the “Balanced Budget Act of 1997” (Public Law 105-33, 111 Stat 256), which drastically cut payments to all physicians and hospitals (now estimated at only about 70% of actual costs) and severely reduced subsidies for education, crippling our academic health centers and arousing great concern among academic health leaders. Severe reduction or losses in these payments are not inconsequential; in 1996, Medicare paid hospitals \$2 billion in direct medical education payments and \$4.3 billion in indirect medical education payments [73]. I envisioned some of these adverse effects in an article published in *Science* in 1993 [74]: “The recent almost frenetic and sometimes chaotic furor over health care reform has generally overlooked the crucial importance and considerable contributions of the nation’s medical centers of excellence for the improved health and longevity of our society. This oversight threatens the stability and integrity of these institutions of research, education, and health care.

The result will be a standstill in new medical knowledge, inadequate training of health professionals, and ultimately, and most important, a decline in the overall quality of health care.”

This jeopardy is reinforced by recent reports of significant financial losses by a number of academic health centers across the country, ranging from \$50 million to more than \$200 million in recent years. Obviously, such losses cannot long endure. According to Pardes [75], “Bankruptcies, massive deficits, layoffs, and merger dissolutions characterize the ominous state of many United States teaching hospitals.” Recently, Pérez-Pena [76] reported the hospital business in New York to be in “deep financial trouble”; some hospitals, in fact, have closed, requiring patients to travel farther for health care. In addition to teaching medical students and specialty trainees and performing medical research, academic health centers serve a vital societal function by providing highly specialized services, such as trauma, burn, neonatal intensive care, organ transplantation, and other complex units requiring costly specialized personnel. They also provide medical care for about half the indigent population in the country. Progressive decreases in reimbursement from Medicare, Medicaid, managed care, and other insurers have forced academic health centers into rigorous cost cutting. These financial losses not only threaten the important highly specialized services they provide their communities but also have a baneful impact on their other essential functions. Medicaid reimbursement retrenchment for physicians’ services and consequent inhibition of patient access has recently been recognized by a federal court in Oklahoma, which ruled that “. . . the state’s Medicaid program did not ensure equal access to eligible children because of insufficient payments to doctors” [77].

### Secondary Effects of Government Involvement

From this overview, it is evident that government has provided ready access and adequate health care for the elderly, as well as for other groups in this country, such as the underprivileged and those with disabilities and end-stage renal disease. Of similar importance has been govern-

Table 6  
Pharmaceutical companies' CEO pay—2003

Firm	Compensation	Options
Merck	\$2,992,334	\$63,721,100
Kos	\$605,715	\$7,153,501
Eli Lilly & Co	\$203,640	\$24,292,300
Novartis	Not available	Not available
Abbott	\$14,356,325	\$2,136,438

Compensation (salary and bonus) as well as options held by the chief executive officers of the 5 pharmaceutical companies in 2003 with the highest EPS.

Data from *The Wall Street Journal Online* (www.online.wsj.com) [69].

ment's earlier strong support of medical education, particularly in the academic health centers, whose medical contributions have greatly enriched the medical culture of the country and elevated the standards of health care.

Equally salient, however, are the thorny and onerous issues government has created. Now threatening the stability and integrity of the medical community are the problems government has encountered in meeting the needs of its growing elderly population in the face of shrinking financial resources and the impediments it has introduced by intrusive, rigidly bureaucratic, overly expansive, sometimes adversarial rules and regulations, which are often inconsistent, contradictory, uninterpretable, and increasingly voluminous. In medicine, we are dealing with a precious human possession—health—not an insensate commodity that is more amenable to bureaucratic rigidity. The apparent inevitability of the federal regulatory role and its tendency to obfuscate rather than clarify is clearly evident in the recent disclosure that the draft of the 2006 106-page Medicare handbook relating particularly to the prescription drug benefit is seriously flawed and will require considerable revision [78]. A corollary, and somewhat appendant, issue is the growing burdensome problem of the nonelderly uninsured, estimated at 45 million [79,80], owing in large measure to the high cost of private medical insurance. This figure may not accurately reflect the true extent of this problem since Stoll and Jones [81] recently reported that in 2002 to 2003, “nearly 82 million people—one of every three Americans—went without health insurance for all or part” of this period and “nearly 8 out of 10 were working.” According to Gilmer and Kronick [82], we will have 63 million uninsured Americans under 65 years of age in 2013.

The acceleration of health care spending poses serious financial challenges not only for the government but also for business and industry. Whereas the economic growth is about 3.6%, growth in health care spending is 9.3%. Consequently, employers are reducing expenses by layoffs, scaling down wages, and curtailing health benefits. This deleterious impact on industry is highlighted by a recent report that General Motors spent \$5.6 billion this year to provide health care for 1.1 million employees and their dependents. For every vehicle produced by this company in the US last year, health care spending amounted to \$1,525, and the company's chief executive attributed much of GM's profit woes to these costs [83].

### Universal Health Insurance

Rather astounding has been the number of self-appointed “pundits” who have facile solutions to the “health care crisis” without ever having studied medicine, seen a patient, battled the physician paper overload, or felt torn by the critical needs of a patient that have to remain unmet because of managed care dictates and financial restraints. An arrant example of the contumely of such comments is this state-

ment in an address to medical students, “If you oppose government interference in your work, you should get out of health care and get into Hula Hoops . . . If you don't want government interference, get out of medicine” [84]. In other words, do not try to correct social or political ills; simply avoid them by leaving them for others to cope with. Moreover, what activity in life is there with no government oversight? Even the facetious example of hula hooping has restrictions and is prohibited, for example, in the middle of a busy thoroughfare.

Advocates of universal health insurance often turn to Canada and European countries as laudable examples of state systems that provide “free and ready” access to medical care for all the people [80]. Frequently cited are the significantly lower health expenditures in these countries than in the United States. In 2002, the United States per capita health care spending was more than \$5,267 or 14.6% of GDP, compared with an average of about \$2,978 or 9.3% of GDP for Germany, Canada, France, Sweden, Japan, Italy, and the United Kingdom [85]. Although the percentage of total health spending on the elderly is not significantly different, the per capita health spending for the elderly is, indeed, about twice as high in the United States as in the other countries (Table 7) [42]. From 1960 to 1997, the percentage of GDP spent on health care in the United States increased from 5.2% to 13.5%, whereas among the other industrial nations the highest increase was from 4.8% to 10.4% in Germany [42]. Havighurst [86] attributed this excess in per capita health care spending in the United States to the fact that “. . . its political and legal institutions have given it the worst of both worlds—regulations and the free market.”

But “free and ready access” is a far cry from the actual delivery of quality medical care. I have traveled the globe to developed and undeveloped countries with both democratic and communistic governments, to serve as Visiting Professor, to consult about various health care activities and to operate on patients—and so have worked in the trenches abroad, and I can state unequivocally that I have not ob-

Table 7  
Health spending for the elderly in 8 countries (1993–1995)

Country	Total health spending on the elderly (%)	Health spending per capita, 1997* (\$)
Australia (1994)	35	5,348
Canada (1994)	40	6,764
France (1993)	35	4,717
Germany (1994)	34	4,993
Japan (1995)	47	5,258
New Zealand (1994)	34	3,870
United Kingdom (1993)	43	3,612
United States (1995)	38	12,090

Modified with permission from Anderson GF, Hussey PS. Population aging: a comparison among industrialized countries. *Health Aff (Millwood)* 2000;19:5.

\* US dollars in purchasing power parities.



served any “universal health system” or other state-operated medical system that functions in a highly satisfactory manner or provides high-quality care to all the people all the time. In all such countries, there are long delays for any form of high-technology care—sometimes with fatal consequences. In fact, rationing of care is a prominent feature of all these systems.

The British National Health Service (NHS), begun in 1948, now costs more than \$139 billion a year. According to Nairne [87], “queuing for a cure . . . and the rationing of care continue to be routine . . .” Because of overflowing emergency rooms, crowded corridors, and waiting lists of about 1 million patients, the overburdened NHS health care workers are now encouraging patients to seek patient-paid physicians. Here again, retrenchment of government funds in the face of an aging population and more costly technology has deteriorated Britain’s socialized medical system. In an effort to address the waiting list, the British government is contracting out more NHS work to independent private firms [88].

That all is not well with the NHS is evident from a recent book by Pollock and colleagues [89] bemoaning the “Privatization of Our Health Care.” This succinct passage appears in the chapter on “The Emerging Health Care Market”: “The NHS is being dismantled and privatized. Very soon, every part of it will have been unbundled and commodified.” They further noted that “This privatization process has migrated to the continent.”

In regard to the vaunted Canadian Health Care system, the Canadian Supreme Court ruling on June 9, 2005, in response to a case of a patient requiring a hip replacement placed on a waiting list, struck down the law banning private medical practice. The Chief Justice wrote that “Access to a waiting list is not access to health care.” The ruling stated “The prohibition on obtaining private health insurance . . . is not constitutional where the public system fails to deliver reasonable services” [90]. In a crisp response to his own question “What reform would do the most harm?” Milton Friedman [91] replied, “Extending government control to all of medical care, i.e., socializing medicine on the Canadian model.”

### Is Health Care a Societal Responsibility?

Do we have an obligation to care for every citizen who is ill? Yes, I believe we do, both as physicians and as members of a compassionate society. Moreover, I believe this responsibility is strongly implied in the American polity established by our founding fathers based on the concept of natural law and natural rights emanating from the Enlightenment and establishing our “right” to life, liberty, happiness, and property. Health is necessarily encompassed in this concept, for without health “life,” in its popular sense, and the attainment of all these “rights” is extremely difficult, if not impossible. It follows, therefore, that the sustainabil-

ity of health is an integral function of the American policy. From a practical standpoint, the good health of all citizens is an economic advantage, since it allows greater productivity and less dependence on compensation from tax funds.

### Caveats

Do I have a panacea for achieving such a goal? No, but I have some caveats to recommend and a proposal toward achieving this goal. First, be very cautious about proponents of radical “restructuring” or “reform” of health care. As I have stated before [74], if “reform” produces improvement in the access, quality, and efficiency of health care delivery, fine, but if it means more cost-cutting by denial or reduction of services, by burdensome and intrusive government regulations, shifting funds from patient care to corporate salaries and higher administration costs, that is not “reform”; it is abuse. In the present climate, I believe that some form of national coverage is inevitable, but I would express grave concern about any form of a total government-operated system such as an “expanded version of traditional Medicare” [92]. In response to a question about health care reform, Victor Fuchs [93] made these comments: “The Clinton plan was a combination of ignorance and arrogance and it turned out to be a disaster. But I never believed for a minute that they could get major health care reform. Health care reform requires a substantial political investment. You’re talking about one-seventh of the economy and huge numbers of interest groups of all kinds. To change the *status quo* in a major way means you have to achieve a tremendous political reform first.” In this connection, at the request of the late Robert Bartley, editor of the *Wall Street Journal* [94], I submitted an op-ed article on the Clinton Health Plan, which Bartley entitled “Prescription for Disaster.”

Aaron [92] provided one of the most trenchant descriptions of the problems with the United States health care system: “Like many other observers, I look at the United States health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggering complex public systems with mind-boggling administrative prices and other rules expressing distinctions that can only be regarded as weird.” The hodge-podge, mish-mash effect seems to be the result of sequential tinkering and patching.

Although considerable change is needed and will undoubtedly occur, let’s not throw out the baby with the bath water. The best features of our system should be preserved, including particularly support of our academic health centers, where future physicians receive quality medical education and training and where imaginative and innovative medical research has led to many dramatic lifesaving advances in health care. Media briefings are appropriate and necessary, but a more intense, deliberative, and sustained educational effort is required for the public, as well as

government officials and industrial leaders, to have a better understanding of the crucial role of the academic health centers in our society.

### Responsibility of the Medical Community

The medical community also has a clear responsibility in this regard. Because of the turmoil in the health care system, many physicians find that they no longer control their professional activities [9,95,96]. Physicians must reclaim their stewardship of their own profession, especially in medical decision making and ethics, both of which must place the welfare of the patient above all else. Medicine must recapture its professionalism and reject the imposition of crass commercialism by profit-driven entrepreneurs [70]. Physicians must become vocal and help educate the public and Congress in the realities of patient care [97]. As I have pointed out previously, “It is our responsibility to inform the public fairly and fully of the insiders’ views of the issues and of the adverse effects of overregulation, irrational restraints, and politically alluring but perilous recommendations” [98]. Only in that way can the public make informed decisions about the kind of health care system they want. It is unrealistic, indeed folly, for society to demand the most advanced and sophisticated health care available, yet balk at its higher cost [99]. As in most other spheres of life, there are no free lunches in medicine. The cost for those who cannot pay must be shifted to others. For physicians to remain passive about these matters while smoldering over the injustice of unreasonable, and sometimes inhumane, rules and regulations is bootless.

There is general agreement that the health care system in the United States, including both the private and public sector, is in need of urgent reform. Toward this objective, a wide array of proposals have been recommended [6,7,11,80,100–109]. These range from limited approaches under the rubric of “incrementalism” to a single-payer system or total government control. Between these 2 extremes are proposals for a pluralistic system combining the private and public sector and other suggestions for stepwise changes. Although some are worthy of review, none in the current political climate would find ready general acceptance. A recent poll, for example, found that 55% of Americans oppose a single-payer health system [110]. The dismal failure of all proposals for radical reform during the past century has been attributed to powerful for-profit special-interest groups that have influenced the legislative process. Another important factor has been the valid concerns of the American people about “distrust of government” [45], “antistatism,” or government control of the health care industry, the largest service industry in the country, amounting to one seventh of the entire economy. Still another factor, and possibly the most important, is “. . . lack of political leadership strong and sustained enough to forge a workable consensus on coverage legislation” [108].

It is vitally important to understand that efforts directed solely at “fixing” or “reforming” Medicare and Medicaid are not only inauspicious but feckless. This opinion is validated by the inability of the National Bipartisan Commission on the Future of Medicare (composed mostly of members of Congress) in 1998 to 1999 even to submit a formal report to Congress [111]. According to Glied [112], the “. . . ideological differences contribute to political deadlock and undermine even incremental reform . . .” There is little hope and faint comfort in the belief that a satisfactory solution even to the Medicare problem can be achieved, or even initiated, in the present political climate in Washington, DC.

The “incrementalism” procedures of the past have not only been a despairing failure but have actually aggravated the national health care problem [113]. An important reason is that although the public sector health expenditure represents less than half (about 45% with Medicare/Medicaid being about 33%) of the total national health expenditure [40,42,46], its impact and influence on the health care system are far greater. As Vladeck and King [36] emphasized, the very size and national character of Medicare have “a profound effect, whether intended or not, on the shape and character of health care and medical practice throughout the country.” All efforts, valiant and urgent as they may be, must therefore be focused on the overall health care system, not on individual segments, however complex they may be in their interrelationships. This may be a Herculean task, but certainly does not have to be a Sisyphean task.

### Recommendations and Conclusions

Health care is too critical for the welfare of the people to be held hostage by the politically motivated or the profit minded. Herein lies the societal challenge: the need for accepting the desirability of some form of national health care, along with the willingness to pay for it, but avoiding its administration and total control by an ultimately rigid and unwieldy governmental or insurance industry bureaucracy.

Our present health care system is unquestionably in disarray. The need is urgent for reform to achieve more effective and more efficient health delivery. I believe the best mechanism to accomplish this objective is the establishment of a high-level commission jointly endorsed and supported by the President of the United States and the Congress, which is *tactically different* from the recommendation of the Committee of the Institute of Medicine [108], that the President and Congress “. . . develop a strategy to achieve universal insurance coverage.” I am emboldened to propose such a commission as a consequence of my personal gratifying participation in 2 such commissions that proved effective: (1) The Hoover Commission [114], which was responsible, among other things, for the establishment of the National Library of Medicine, and (2) President Johnson’s Commission on Heart Disease, Cancer, and Stroke [115].

which was responsible, among other things, for the National Library of Medicine's Outreach program and the National Cancer Institute Designated Comprehensive Cancer Centers. What is essential here are bold initiatives and focused and resolute leadership. In order to secure legitimacy and the nation's esteem, the members of this commission should be meticulously selected for their nonpartisanship, integrity, vision, and documented expertise in all aspects of the multifarious health care system, with broad representation of the various participating disciplines, including medical practice, medical education, medical research, medical administration, hospital administration, medical ethics, medical economics, insurance, and other related fields. The mission should be explicitly defined to consider, contemplate, and analyze all the dynamics, features, and components of our current health care complex and provide a "roadmap" toward achieving universal health care coverage that is culturally acceptable, affordable, and of optimal quality. The commission should be adequately funded and given a deadline for completion of its studies and issuance of its recommendations in 1 to 2 years. Although at first glance this suggestion for a comprehensive exploration and reconstruction of our entire health care system may seem drastic, I rather envision it as a Fabius-like strategy, to which the words of Virgil [116], which appear on the reverse side of the Great Seal of the United States of America, seem apropos: "Look with favor upon a bold beginning."

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